Federal Health Reform: Overview & Considerations for the Oregon Health Policy Board

Oregon Health Policy Board meeting
April 13, 2010

Based on current OHA Staff understanding

Overall impact of federal law

- **Population health**
  - Significant funding opportunities to enhance and integrate prevention and health promotion in state and community health policy planning
  - Substantial increase in community health centers funding
- **Delivery system reform**
  - Funding allows experimentation with new models of payment and care delivery
  - Will change Oregon's federal revenue

    (e.g., Medicaid primary care increase 2013-14; additional Medicare hospital payments FY 2011-12; Medicare Advantage reductions start 2012)
  - Strengthens the federal focus and state support of value & quality

Overall impact of federal law

- **Coverage and Access in 2014**
  - Low-income adults up to 133% of poverty will have access to Medicaid with increased federal funding to support expansions
  - Federally-funded tax credits and cost-sharing reductions provided through a state health insurance exchange to individuals up to 400% of poverty
  - Individual mandate requires insurance coverage for all citizens (with some exceptions)
  - Insurance reforms remove barriers to coverage

What the federal law doesn't do

- **Population health**
  - No fundamental change to relationship between public health and health care; states and communities need to capitalize on funding opportunities to support system transformation
- **Delivery system reform**
  - Limited provisions for cost containment
  - May not fully address workforce shortages
- **Coverage**
  - Does not allow states to apply for waivers until 2017
  - Fails to get to universal coverage (can opt-out of individual mandate)
  - Still may not fully address affordability issues

Overview: Improving Population Health

- Significant investments in prevention and public health, examples include:
  - $25m nationally for childhood obesity prevention; could enable implementation of state obesity prevention taskforce recs.
  - $190m nationally to strengthen public health surveillance; could increase state's capacity to monitor and control infectious disease
- HHS to develop national prevention and health promotion strategy
- Grants for school-based health centers, oral health, others
- Menu labeling required in chain restaurants (20+ locations) and vending machines

Overview: Transforming Care Delivery

- **Payment Reform**
  - Increases Medicaid reimbursement for primary care services to 100% of Medicare at federal expense (2013-2014 only)
  - Medicaid medical home demonstration – planning grants and enhanced federal Medicaid match for implementation (starts 2011)
  - CMS Innovation Center to develop payment and other delivery system reforms
- **Medicare Payment**
  - Increases reimbursement to hospitals in Oregon (FY2011-2012 only)
  - Reduces Medicare Advantage payments (starts 2012)

Overview: Transforming Care Delivery

- **Community Health Center Funding**
  - Increases access to services for vulnerable populations through $11 billion nationally for CHCs from 2011-2015
- **Behavioral Health Integration**
  - Grants for co-location of primary and specialty care in community-based mental health setting, $50M available nationally beginning in 2010
- **Workforce**
  - Funding, pilots, and other opportunities for workforce development, coordination, training, and loans/repayment

Overview: Transforming Care Delivery

- **Quality Standards**
  - HHS to develop national quality improvement strategy
  - CMS to create quality standards for adult care in Medicaid
- **Administrative Simplification**
  - Requires compliance with new and revised HIPPA standards for electronic transactions (2013-2016)
  - Medicare providers must accept electronic remittance advice and funds transfer (starts 2014)
- **Comparative Effectiveness**
  - Establishes Patient-Centered Outcomes Research Institute to provide research and guideline development

Overview: Coverage and Access to Care

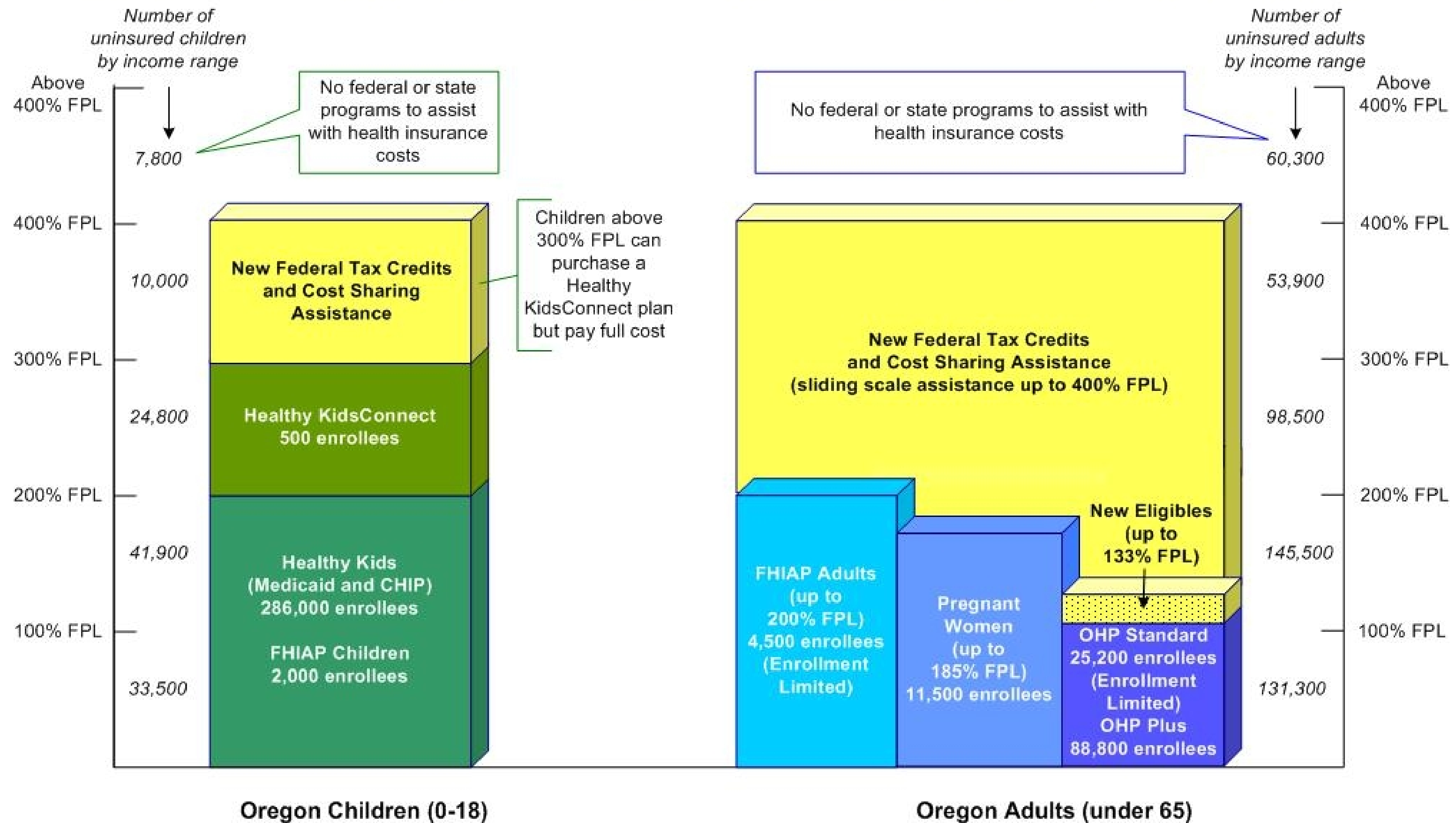
- **Early Benefits**
  - Young adults on parents' health plans
  - Prohibition on pre-existing condition exclusions for children
  - Prohibition against rescinding coverage after enrollment except in cases of fraud
  - Prohibition against lifetime benefit caps

Overview: Coverage and Access to Care

- **Medicaid/Children's Health Insurance Program (CHIP)**
  - Coverage expansion for all individuals under age 65 up to 133% and former foster children at all income levels up to age 26 (starts 2014)
  - Enhanced federal funding for new eligibles
    - 100% in 2014-16
    - 95% in 2017
    - 94% in 2018
    - 93% in 2019
    - 90% in 2020 and beyond
  - Starting in 2015, federal match for CHIP match goes up 23 points
  - Gradually reduces disproportionate share hospital payments based on uninsurance rates (2014-2020)
  - States must maintain eligibility levels for adults until Exchange is fully operational, and for children until 2019

Overview: Coverage and Access to Care

- **Exchange**
  - States establish Exchanges for individuals and small employer groups with <100 employees (starts 2014)
  - Individuals and small groups can still buy insurance outside of Exchange
  - HHS defines minimum benefit package to be offered in Exchange
  - Federal premium tax credits and cost-sharing reductions
    - Reduce premiums for individuals 100%-400% FPL on a sliding scale (starts 2014)
    - Federal payments reduce out-of-pocket limit (starts 2014)
    - Tax credits and cost-sharing reductions only available through the Exchange
- **Public Plan**
  - No federal public plan; does not preclude state exploration of a public plan



Federal expansions reflect H.R. 3590, passed by the Senate in 2009.
All figures are rounded to the nearest hundred.
Program enrollment figures are the most current available on March 1.
Uninsured numbers are from the 2009 American Community Survey report.
Oregon populations figures for total children and adults under 65 are from Population Research Center at Portland State University, Dec. 2009

Overview: Coverage and Access to Care

- **High-Risk Pool**
  - Temporary national high-risk pool created (within 90 days of enactment until Jan. 2014)
- **Small Business/Employer Responsibility**
  - Tax credits to low-wage small employers to purchase coverage (2010-2013) and purchase through the Exchange (starts 2014)
  - Assessments on employers (> 50 FTE) whose employees receive tax credits or cost-sharing reductions (starts 2014)
- **Individual Responsibility**
  - Individuals must have qualifying health coverage, unless unaffordable (if premium >8% of income); phased-in tax penalty (2014-2016)

Overview: Coverage and Access to Care

- **Insurance Regulation**
  - Guaranteed issue and renewability (starts 2014)
  - Pre-existing conditions exclusions prohibited (for children 6 months from enactment and for adults by 2014)
  - Prohibits lifetime limits, allows certain annual limits until 2014
  - Eliminates waiting periods of more than 90 days for group coverage (starts 2014)
- **Reinsurance**
  - Temporary federal reinsurance program for early retiree benefits (within 90 days of enactment until Jan. 2014)
  - Transitional reinsurance program, individual and small group (2014-2016)

Federal Health Reform Timeline Highlights

- **2010**
  - Temporary national high-risk pool (June 2010 until Jan. 2014)
  - Dependent coverage for adult children up to age 26
  - Prohibitions on lifetime limits; certain annual limits until 2014
  - Temporary federal reinsurance program for early retirees (June 2010)
- **2011**
  - Develop a national quality improvement strategy
  - New annual fees on the pharmaceutical manufacturing sector
- **2012**
  - Require enhanced data collection and reporting on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations

Federal Health Reform Timeline Highlights

- **2013**
  - Simplify health insurance administration
  - Increase Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100% federal funding
- **2014**
  - Medicaid expansions and health insurance tax credits begin
  - Excise tax on individuals without qualifying health coverage (phase-in 2014-2016)
  - Excise tax on employers (> 50 FTE) whose employees receive tax credits or cost-sharing reductions
  - Establish state Exchanges
  - Limit on waiting periods for coverage to 90 days
  - Annual fee on the health insurance premiums (starts 2014)
- **2015 and later**
  - Excise tax on high-cost plans (Jan. 2018)

Key Issues

- Timing: Do we go early? Do we continue with initiatives that will be superseded by the federal legislation?
  - Should Oregon explore setting up an Exchange sooner than 2014?
  - Should OHA implement standards for electronic transactions since federal ones starting in 2013 will supersede them?
  - Should OHA continue to work on a small business plan that will be superseded by the Exchange?
  - Should OHA expand Medicaid and/or subsidy assistance programs prior to 2014?
  - Should OHA continue work on an essential benefit package when HHS will be setting packages for the Exchange?

Key Issues

- **Should we do more?**
  - Should Oregon have a public plan to sell inside and/or outside the Exchange?
  - Should there be additional state-funded assistance in the Exchange to help lower costs to Oregonian's?
  - HHS will designate the essential benefit services for plans offered in the Exchange. If Oregon chooses to require additional benefits, it must pay for them.

Key Issues

- **Where there is federal flexibility, how do we ensure strategic alignment of design choices?**
  - Should Oregon explore working with other states on a regional (multi-state) Exchange?
  - Should Oregon's Exchange be operated by the state or contracted to a non-profit entity?
  - Should Oregon run separate individual and small group market exchanges or have a single Exchange for both markets?
  - Should Oregon pursue state-based reinsurance or other risk adjustment mechanisms for the multi-share programs or Healthy KidsConnect?
  - Should/can multi-share programs be integrated into an Exchange or CO-OP program and, if so, when?

Key Issues

- How do we ensure strategic alignment of funding and pilot opportunities presented by federal reform?
  - Which funding or pilot opportunities best support the state's strategic objectives for population health, delivery system reform?